SERFF Tracking Number:	*HUMA-125805451*	*State:*	*Arkansas*
Filing Company:	*American Dental Providers of Arkansas, Inc.*	*State Tracking Number:*	*40183*
Company Tracking Number:			
TOI:	*H10G Group Health - Dental*	*Sub-TOI:*	*H10G.000 Health - Dental*
Product Name:	*AR APP Maint- ADPAI*		
Project Name/Number:	*/*		

Filing at a Glance

Company: American Dental Providers of Arkansas, Inc.

Product Name: AR APP Maint- ADPAI	SERFF Tr Num: HUMA-125805451	State: ArkansasLH
TOI: H10G Group Health - Dental	SERFF Status: Closed	State Tr Num: 40183
Sub-TOI: H10G.000 Health - Dental	Co Tr Num:	State Status: Approved-Closed
Filing Type: Form	Co Status:	Reviewer(s): Rosalind Minor
	Authors: Susan Ortiz, Berthena Reed, Xai Xiong	Disposition Date: 10/06/2008
	Date Submitted: 09/05/2008	Disposition Status: Approved-Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

General Information

Project Name:	Status of Filing in Domicile: Not Filed
Project Number:	Date Approved in Domicile:
Requested Filing Mode: Review & Approval	Domicile Status Comments:
Explanation for Combination/Other:	Market Type: Group
Submission Type: New Submission	Group Market Size: Small and Large
Overall Rate Impact:	Group Market Type: Employer
Filing Status Changed: 10/06/2008	
State Status Changed: 10/06/2008	Deemer Date:
Corresponding Filing Tracking Number:	

Filing Description:

Group filing. See cover letter for details.

Company and Contact

Filing Contact Information

Xai Xiong, Application Project Analyst xxiong@humana.com

SERFF Tracking Number:	*HUMA-125805451*	*State:*	*Arkansas*
Filing Company:	*American Dental Providers of Arkansas, Inc.*	*State Tracking Number:*	*40183*
Company Tracking Number:			
TOI:	*H10G Group Health - Dental*	*Sub-TOI:*	*H10G.000 Health - Dental*
Product Name:	*AR APP Maint- ADPAI*		
Project Name/Number:	*/*		

2 Riverwood Place
Waukesha, WI 53188

(262) 951-2633 [Phone]

Filing Company Information

American Dental Providers of Arkansas, Inc.	CoCode: 11559	State of Domicile: Arkansas
The Corporation Company	Group Code: 119	Company Type:
425 W. Capitol Ave.		
Little Rock, AR 72201	Group Name:	State ID Number:
(305) 262-1333 ext. [Phone]	FEIN Number: 58-2302163	

SERFF Tracking Number:	*HUMA-125805451*	*State:*	*Arkansas*
Filing Company:	*American Dental Providers of Arkansas, Inc.*	*State Tracking Number:*	*40183*
Company Tracking Number:			
TOI:	*H10G Group Health - Dental*	*Sub-TOI:*	*H10G.000 Health - Dental*
Product Name:	*AR APP Maint- ADPAI*		
Project Name/Number:	*/*		

Filing Fees

Fee Required?	Yes
Fee Amount:	$100.00
Retaliatory?	No
Fee Explanation:	$20 per form x 5 forms= $100
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
American Dental Providers of Arkansas, Inc.	$100.00	09/05/2008	22316804

SERFF Tracking Number:	*HUMA-125805451*	*State:*	*Arkansas*
Filing Company:	*American Dental Providers of Arkansas, Inc.*	*State Tracking Number:*	*40183*
Company Tracking Number:			
TOI:	*H10G Group Health - Dental*	*Sub-TOI:*	*H10G.000 Health - Dental*
Product Name:	*AR APP Maint- ADPAI*		
Project Name/Number:	*/*		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	10/06/2008	10/06/2008

Objection Letters and Response Letters

Objection Letters				Response Letters		
Status	**Created By**	**Created On**	**Date Submitted**	**Responded By**	**Created On**	**Date Submitted**
Pending Industry Response	Rosalind Minor	09/09/2008	09/09/2008	Xai Xiong	10/03/2008	10/06/2008

SERFF Tracking Number:	*HUMA-125805451*	*State:*	*Arkansas*
Filing Company:	*American Dental Providers of Arkansas, Inc.*	*State Tracking Number:*	*40183*
Company Tracking Number:			
TOI:	*H10G Group Health - Dental*	*Sub-TOI:*	*H10G.000 Health - Dental*
Product Name:	*AR APP Maint- ADPAI*		
Project Name/Number:	*/*		

Disposition

Disposition Date: 10/06/2008
Implementation Date:
Status: Approved-Closed
Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*HUMA-125805451*	*State:*	*Arkansas*
Filing Company:	*American Dental Providers of Arkansas, Inc.*	*State Tracking Number:*	*40183*
Company Tracking Number:			
TOI:	*H10G Group Health - Dental*	*Sub-TOI:*	*H10G.000 Health - Dental*
Product Name:	*AR APP Maint- ADPAI*		
Project Name/Number:	*/*		

Item Type	Item Name	Item Status	Public Access
Supporting Document	Certification/Notice	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Cover Letter	Approved-Closed	Yes
Supporting Document	Statement of Variability	Approved-Closed	Yes
Form	Business Profile	Approved-Closed	Yes
Form	Small Group Medical	Approved-Closed	Yes
Form	Evidence of Health Status	Approved-Closed	Yes
Form	HumanaDental	Approved-Closed	Yes
Form	No Worry Program	Approved-Closed	Yes

SERFF Tracking Number:	*HUMA-125805451*	*State:*	*Arkansas*
Filing Company:	*American Dental Providers of Arkansas, Inc.*	*State Tracking Number:*	*40183*
Company Tracking Number:			
TOI:	*H10G Group Health - Dental*	*Sub-TOI:*	*H10G.000 Health - Dental*
Product Name:	*AR APP Maint- ADPAI*		
Project Name/Number:	*/*		

Objection Letter

Objection Letter Status	Pending Industry Response
Objection Letter Date	09/09/2008
Submitted Date	09/09/2008
Respond By Date	

Dear Xai Xiong,

This will acknowledge receipt of the captioned filing.

Objection 1

- Small Group Medical (Form)
- Evidence of Health Status (Form)
- HumanaDental (Form)

Comment: Will these forms be used as a stand alone form. If so, they must contain a Fraud Statement.

Please feel free to contact me if you have questions.
Sincerely,
Rosalind Minor

Response Letter

Response Letter Status	Submitted to State
Response Letter Date	10/03/2008
Submitted Date	10/06/2008

Dear Rosalind Minor,

Comments:

Response 1

Comments: These forms will not be used as a stand alone form.

The Small Group Medical (AR-80123-SG 8/2008) and HumanaDental (GN-80123-HD 8/2008) will always be used with the Employer Group Application (AR-80123-BP 8/2008) which contains a fraud statement on the second page under “Employer Agreement”.

The Evidence of Health Status (GN-72000-HS 7/2008) will always either be used with the Employee Enrollment

Application (AR-72000 1/2008), or after the Employee Enrollment Application is completed- but only if the employee is choosing life over the guarantee issue amount or if they are a late enrollee choosing life, and they did not already provide us with this information in the Employee Enrollment Application. The Employee Enrollment Application was filed and approved on 1/16/2008, Serff # HUMA-125428885, and contains the fraud statement on page 3 under "Agreement".

Related Objection 1

Applies To:

- Small Group Medical (Form)
- Evidence of Health Status (Form)
- HumanaDental (Form)

Comment:

Will these forms be used as a stand alone form. If so, they must contain a Fraud Statement.

Changed Items:

No Supporting Documents changed.

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

Sincerely,
Berthena Reed, Susan Ortiz, Xai Xiong

SERFF Tracking Number:	*HUMA-125805451*	*State:*	*Arkansas*
Filing Company:	*American Dental Providers of Arkansas, Inc.*	*State Tracking Number:*	*40183*
Company Tracking Number:			
TOI:	*H10G Group Health - Dental*	*Sub-TOI:*	*H10G.000 Health - Dental*
Product Name:	*AR APP Maint- ADPAI*		
Project Name/Number:	*/*		

Form Schedule

Lead Form Number:

Review Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed	AR-80123-BP 8/2008	Application/ Enrollment Form	Business Profile	Initial		40	AR-80123-BP-0808.pdf
Approved-Closed	AR-80123-SG 8/2008	Application/ Enrollment Form	Small Group Medical	Initial		40	AR-80123-SG-0808.pdf
Approved-Closed	GN-72000-HS 7/2008	Application/ Enrollment Form	Evidence of Health Status	Initial		40	GN-72000-HS-0708.pdf
Approved-Closed	GN-80123-HD 8/2008	Application/ Enrollment Form	HumanaDental	Initial		40	GN-80123-HD-0808.pdf
Approved-Closed	GN-80123-NW-SB 2/2008	Application/ Enrollment Form	No Worry Program	Initial		40	GN-80123-NW-SB-0208.pdf

Internal use only

Group number:

Employer Group Application

[Arkansas]
HUMANA / HUMANADENTAL

Please refer to your proposal to complete this application. This document will form part of any contract issued. Print clearly in black ink, and answer all questions or indicate "not applicable."

Your Business Profile

Business name | Federal tax ID number

Location address (not a P.O. Box)

City | State | Zip code | County

Do you have more than one location? ❍ No ❍ Yes

Billing address (if different)

City | State | Zip code | County

Nature of business or SIC number | Date company established

Business status: ❍ Corporation ❍ Partnership ❍ Sole Proprietorship ❍ Other: (explain)

Business phone number | Fax number

Management contact | Administrative contact

Management contact e-mail address

Management contact: Mother's maiden name _____

This will be used to gain access to the Employer Self-Service Center on www.Humana.com.

General Eligibility

Requested effective date | [How many employees are on your payroll?]

[How many hours per week must your employees work to be eligible? (select between [0-20] and [0-40] hours)]

[Do you want to exclude a class of employees? ❍ No ❍ Yes]

[If yes, check class to exclude: (Options vary by plan. Refer to the Underwriting Requirements for each plan.)

❍ union ❍ non union ❍ hourly ❍ salary ❍ management ❍ non-management]

[How long must employees wait after hire date to become eligible? ❍ 0 days ❍ 30 days ❍ 60 days ❍ 90 days ❍ Other, specify:]

[How many employees are eligible for coverage?]

[New employee effective date provision: ❍ First of month following waiting period ❍ Immediately following waiting period]

[On all plans, the employee termination date coincides with the effective date provision.]

[Is this employer required to comply with COBRA regulation? ❍ No ❍ Yes]

[Is this employer required to comply with state continuation regulation? ❍ No ❍ Yes]

[Are any present or former employees/dependents currently on or eligible to elect COBRA/State Continuation? ❍ No ❍ Yes]

[If yes, enter information below. Attach a separate sheet if necessary.

Name of applicant	Qualifying event (e.g., termination of employment, divorce, etc.)	Date of qualifying event	Date COBRA or State Continuation coverage terminates]

Employer Agreement

You the employer, understand, agree and represent:

- You have read this document and the information you provided is accurate and complete to the best of your knowledge and belief and can be substantiated by your business records.
- You have received and reviewed a proposal and the applicable regulatory information required by your state.
- Neither you nor the agent/broker/producer has the authority to waive a complete answer to any question, determine coverage or insurability, alter any contract, bind us by making any promise or representation, or waive any of our other rights or requirements. No waiver or change will bind us unless signed by an authorized officer of our company.
- The first month's estimated premium (which may include a monthly administrative fee), and fully completed enrollment information for all eligible persons requesting insurance coverage must be submitted with this application before action is taken on this application. Unless we are informed differently, we will perform a one-time electronic check conversion of the first month's premium payment from the account and for the amount designated on the binder check.
- You will collect any employee contribution toward premium. Our acceptance of premium does not guarantee coverage.
- You will provide the documentation requested by us which establishes that all eligibility, underwriting, and participation requirements of the plan are met.
- Only individuals who meet the eligibility requirements of the plan are eligible to maintain coverage.
- Providing incomplete, inaccurate, or untimely information may void, reduce, or increase past premium, or terminate an individual's coverage or the group's coverage.
- If choosing the HDHP Indexing plan, deductible and out of pocket amounts are established by IRS guidelines. Adjustments to these amounts by the IRS will be made to the policy, without notice, upon renewal of the group.
- Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application of insurance is guilty of a crime and may be subject to fines and confinement in prison.

This document will form part of any contract issued. Coverage is not in effect unless and until you receive written notification from us.

If this application is declined, we will return the premium deposit submitted with this application.

Do not cancel any current group coverage until you receive written notice from us that we have issued coverage.

Dated on:_____ By:_____
(month, date, year) (employer signature)

Dated at:_____ By:_____
(city and state) (title)

Agent/Producer Information

1. Agent/Agency of Record (for commissions and correspondence):	**2. Agent/Agency of Record (for split-commissions):**
Name (print)	Name (print)
Tax ID / Social Security Number / Humana Agent Number	Tax ID / Social Security Number / Humana Agent Number
Commission split: ❍ No ❍ Yes If yes, percentage: (total should equal 100%)	Percentage of sales: ❍ No ❍ Yes If yes, percentage: (total should equal 100%)
1. Writing Agent/Producer:	**2. Writing Agent/Producer:**
Name (print)	Name (print)
Social Security Number / Humana Agent Number	Social Security Number / Humana Agent Number
Commission split: ❍ No ❍ Yes If yes, percentage: (total should equal 100%)	Percentage of sales: ❍ No ❍ Yes If yes, percentage: (total should equal 100%)

General Agency

General agency information pertains to ❍ Agent/Agency of Record #1 ❍ Agent/Agency of Record #2

Name (print) Tax ID / Humana Agent Number

Address City State Zip code

As the Writing Agent/Producer, I acknowledge that I am responsible to meet with the employer submitting this application in order to fully and accurately represent the terms and conditions of the plans and services of the offering or insuring entity, or one of its subsidiaries. These provisions are available to me and the employer in the Regulatory Pre-enrollment Disclosure or other plan literature.

Writing Agent's Signature:_____ Date:_____

The following applies to all companies and products

The companies listed on this Employer Group Application, severally or collectively as the context may require, are referred to in this application as we, us and our.

You, the participating employer, policyholder, contractholder, or group plan sponsor, intend to establish, sponsor, and endorse an employee benefit plan which will be governed by Employee Retirement Income Security Act of 1974 (ERISA). You are the ERISA plan administrator.

Small employer means a person, firm, corporation, partnership or association actively engaged in business, which employed an average of at least two but not more than 50 employees on business days during the preceding calendar year and who employs at least two employees on the first day of the plan year, unless otherwise provided under the state law. Entities that are affiliated companies or that are eligible to file a combined tax return for the purpose of taxation, are considered one employer.

You agree to make available your records which we determine are relevant to this application and group coverage for inspection by the Trustee, Administrator, us or our representative during your normal business hours.

As claims administrator with authority to make claim determinations as described in Section 503 of ERISA, we make final decisions under the Policy or Group Plan with respect to determining eligibility for coverage and paying claims for benefits, including deciding appeals of denied claims. As claims administrator, we shall have full and exclusive discretionary authority to 1) interpret Policy or Group Plan provisions, 2) make decisions regarding eligibility for coverage and benefits, and 3) resolve factual questions relating to coverage and benefits.

You understand and agree that failure to remit and pay premium when due will be considered a default in premium payment, and that coverage will be terminated by us, following a grace period of 31 days from the date of non-payment of premium. We may terminate your coverage according to the termination section of the Policy or Group Plan. Except for non-payment of premium or when a group or individual is not or has not been eligible for coverage, you will be provided with a 30 day advance written notice, unless a greater period is expressly specified in the Policy. If coverage is terminated by us for non-payment of premium, you will still owe and we will collect all due premium including premium for the grace period.

You understand and agree that your coverage is renewed on a monthly basis subject to timely payment of premium. We reserve the right to change the premium rates on any premium due date, as permitted by applicable law, after your insurance has been in effect under the Policy for six consecutive months. You will receive advance written notice.

For you to remain eligible for the Policy or Group Plan, the eligibility, underwriting and participation requirements must be maintained, for each respective coverage. Failure to maintain the plan eligibility, underwriting and participation requirements will terminate your coverage under the Policy or Group Plan. Other termination provisions are stated in the Policy or Group Plan.

Based upon our standard underwriting practice, we may require an employee or dependent to submit Evidence of Health Status. We have the right to use the information provided by you and any applicant (employee or dependent) to determine whether coverage will be provided, to determine eligibility and to establish appropriate premiums. Any health related information that has been provided will not be used to decline medical coverage unless permitted by law.

The following applies for [No Worry] medical plans

If you purchase a No Worry medical plan and fail to maintain your Humana group medical insurance plan during the No Worry plan period and purchase group medical insurance with another carrier, you agree to pay an early termination fee according to the program parameters specified below. Your payment obligation must be satisfied no more than [0-180] days from the termination date of your group medical plan. If you discontinue offering group medical insurance, or go out of business, you do not need to pay the early termination fee.

[Employers with [51-99] eligible employees]:

- [The early termination fee is [$0-75,000] for termination after the [0-first] year, [$0-75,000] for termination after the [second-fifth] year.]
- [The plan period is [0-5] years from the effective date of the [No Worry] plan.]]

Employers with [100-300] eligible employees:

- The early termination fee is equal to one month's premium, based on the premium rate established for the following year and enrollment during the last full month of coverage.
- If you request group experience within [0-15] months of the effective date of your No Worry program, the premium rate for the subsequent year will not be guaranteed.
- [The plan period is [0-5] years from the effective date of the [No Worry] plan.]]

HUMANA®
Guidance when you need it most

[Medical], [Life] and [Short-Term Income Protection] [plans] insured or administered by [Humana Insurance Company].

HUMANA®
Specialty Benefits

[Dental] [plans] insured or administered by [HumanaDental Insurance Company], [CompBenefits Insurance Company], [American Dental Providers of Arkansas, Inc.] or [Humana Insurance Company]. [Vision] [plans] insured or administered by [Humana Insurance Company] or [CompBenefits Insurance Company].

[2-99] total employees on payroll

Humana Small Group Medical

[ARKANSAS]
EMPLOYER GROUP APPLICATION

Plan Selection (To complete this information, refer to your proposal.)

	Plan 1	Plan 2	Plan 3
Plan name (as shown on your proposal)			
Office visit copayment (if applicable)	$	$	$
Coinsurance (if applicable)	Participating (In) : %_____ Non-participating (Out): % _____	Participating (In) : %_____ Non-participating (Out): % _____	Participating (In) : %_____ Non-participating (Out): % _____
Deductible (if applicable)	Participating: $ Non-participating: $	Participating: $ Non-participating: $	Participating: $ Non-participating: $
Out-of-pocket limit (if applicable)	Participating: $ Non-participating: $	Participating: $ Non-participating: $	Participating: $ Non-participating: $
Network name (if applicable)			

Plan Riders (Please refer to your proposal for rider availability with plan selected.)

Deductible Carryover Credit	❍ No ❍ Yes	❍ No ❍ Yes	❍ No ❍ Yes
Supplemental Accident	❍ No ❍ Yes	❍ No ❍ Yes	❍ No ❍ Yes
Prescription Drug/Retail Card (Level 1 / 2 / 3 / 4)	$_____ /$_____ /$_____ /_____%	$_____ /$_____ /$_____ /_____%	$_____ /$_____ /$_____ /_____%
Prescription Drug/Retail Card (Group A / B / C / D)	$____a /$____a /$____a /$____a	$____a /$____a /$____a /$____a	$____a /$____a /$____a /$____a
Other:	❍ No ❍ Yes	❍ No ❍ Yes	❍ No ❍ Yes
Special State Options: • optional chemical dependence & alcoholism benefit	❍ No ❍ Yes	❍ No ❍ Yes	❍ No ❍ Yes
• optional speech and hearing benefit	❍ No ❍ Yes	❍ No ❍ Yes	❍ No ❍ Yes

Underwriting Requirements

- You may not sponsor a medical plan from a carrier other than Humana.
- Medical coverage is available to employers with [two or more] enrolled employees.
- If the only employees of a two-life group are husband and wife, each must enroll separately as an employee and maintain eligibility. The group is only eligible if a bona fide business entity exists.
- If less than [26-99] employees are enrolled, you must submit evidence of health status for all employees and dependents. We will not use the evidence of health status to decline medical coverage.
- Minimum employer contribution toward employee premium is [0-50]%.
- Retiree coverage is available to employers with [26 or more] enrolled employees.
- Minimum age for retiree coverage is [0-65] for employers with [26 to 50] enrolled employees.
- There are no excluded class options for small group medical coverage.
- If you do not maintain eligibility, underwriting, and participation requirements, we will terminate your coverage.

Participation

- non-contributory plans – [0-100]%
- contributory plans – [0-75]%

Group Information

[How much will you contribute to premium? Employee _____% Dependent _____%]

[Do you wish to have 24-hour coverage for employees not covered by Workers' Compensation? ❍ No ❍ Yes]
[If yes, name(s):]

[Are there any other entities associated with this company that are eligible to file a combined tax return? ❍ No ❍ Yes]
[If yes, enter information below.

Company Name	Total Employees]

[Will your employees have access to another carrier's medical coverage by virtue of their employment with you? ❍ No ❍ Yes]
[If yes, name of carrier:]

Group Information (continued)

[Did you have prior group medical coverage? ❍ No ❍ Yes] [If yes, submit most recent carrier billing with effective and termination dates.]

[How many medical carriers have you had in the past five years?]

[Is the agent/broker/producer representing you for this application your current agent/broker/producer of record? ❍ No ❍ Yes]

Provide the current and renewal medical insurance premium rates below and attach a copy of your most recent premium bill.
Date of renewal:

Current Plan 1 current carrier rates:	**Current Plan 2 current carrier rates:**
Employee: $_____ Spouse: $_____ Child(ren): $_____ Family: $_____	Employee: $_____ Spouse: $_____ Child(ren): $_____ Family: $_____
Plan design:	Plan design:
Office visit copay:	Office visit copay:
Per confinement copay:	Per confinement copay:
Deductible: • Participating _____ • Non-participating _____	Deductible: • Participating _____ • Non-participating _____
Out-of-pocket: • Participating _____ • Non-participating _____	Out-of-pocket: • Participating _____ • Non-participating _____
Coinsurance stoploss: • Participating _____ • Non-participating _____	Coinsurance stoploss: • Participating _____ • Non-participating _____
Emergency room copay:	Emergency room copay:
Prescription drug benefit:	Prescription drug benefit:
[Do you as the employer currently fund any of the plan deductible for the employees? ❍ No ❍ Yes] [If yes, how much of the deductible do you fund?]_____	[Do you as the employer currently fund any of the plan deductible for the employees? ❍ No ❍ Yes] [If yes, how much of the deductible do you fund?]_____
Renewal rates: In the parentheses, please indicate the number of employees enrolled in each tier, if available. Employee ( ): $_____ Spouse ( ): $_____ Child(ren) ( ): $_____ Family ( ): $_____	**Renewal rates:** In the parentheses, please indicate the number of employees enrolled in each tier, if available. Employee ( ): $_____ Spouse ( ): $_____ Child(ren) ( ): $_____ Family ( ): $_____

1. [Has any employee been unable to work [0-10] or more consecutive days in the past [0-12] months due to an illness or injury? ❍ No ❍ Yes]
2. [Is any employee presently not performing his or her duties on a full-time basis due to an illness or injury? ❍ No ❍ Yes]
3. [To the best of your knowledge, is there any employee, individual in a retiree class, dependent (spouse or child), COBRA beneficiary, or individual within their COBRA/State Continuation election period:
   - ❍ [confined at home, in a hospital, or in a treatment facility;]
   - ❍ [who incurred more than [$0-10,000] of medical expenses in the past [0-24] months;]
   - ❍ [who has been advised within the last [0-90] days to have surgery or be hospitalized;]
   - ❍ who received treatment, had treatment recommended, or had medication prescribed by a doctor, psychiatrist, psychologist or other licensed practitioner within the past [0-24] months for any of the following: (check all that apply)
     - ❍ [AIDS or an AIDS-related complex or other immune system disorder]
     - ❍ [Alcohol or drug abuse or dependence, or psychological disorder]
     - ❍ [Cancer or cancerous tumor]
     - ❍ [Heart or vascular disease or stroke]
     - ❍ [Diabetes or any disease or disorder of the kidneys, liver or lungs]
     - ❍ [Systemic disease including, but not limited to Lupus, Multiple Sclerosis, or Muscular Dystrophy]
     - ❍ [Organ transplant (other than corneal)]]

[If you answered yes to questions 1-3 above, please indicate the question number and explanation.

Question #	Member Status*	Age	Medical Condition/ Diagnosis	Date(s) of Treatment	Medication Name/Dosage	Past/Current/Future Treatment]

** Member Status: E=Employee D=Dependent C=COBRA/State Continuation R=Retiree Class*

Group Information (continued)

[Has your company, at any time during the past [0-24] months, had medical coverage terminated or a renewal of medical coverage refused? ❍ No ❍ Yes] [If yes, please explain:]

[Have any medical benefits now, or within the past [0-24] months, been funded by you in any manner other than health insurance premium payment? ❍ No ❍ Yes] [If yes, please provide details and attach medical claims experience for the applicable time period up to [0-24] months.]

Retiree Information

[Are you offering coverage to retirees? ❍ No ❍ Yes] [If yes, required age: Minimum years of service:]

[Group number:]	Last name:	First name:

Evidence of Health Status

Relationship	Last name, First name MI	Height (ft / in)	Weight (lbs.)	[Disabled?] [If yes, indicate reason.		SSN #
Employee		/		❍ N ❍ Y	Reason:	
Spouse		/		❍ N ❍ Y	Reason:	
Child		/		❍ N ❍ Y	Reason:	
Child		/		❍ N ❍ Y	Reason:	
Child		/		❍ N ❍ Y	Reason:	
Other (specify):		/		❍ N ❍ Y	Reason:]	

This information should not be submitted more than [0-60] days prior to the effective date.
Complete this section for applicants requesting Life insurance over the guarantee issue amount and all late enrollees applying for Life coverage.

[1. Are you or any dependent currently under any treatment or prescribed medications?	❍ N ❍ Y]

[2. Within the past [0-5] years, have you or any eligible dependent to be covered been diagnosed with, counseled, consulted or treated by a doctor for any of the following:]

a	Coronary artery disease, chest pain, or any disease of the arteries or blood vessels; phlebitis; high blood pressure?	❍ N ❍ Y	f	Diabetes; liver or thyroid disease; or enlargement of the lymph nodes?	❍ N ❍ Y
b	Nervous, mental or emotional disorder; convulsions; epilepsy; unconsciousness?	❍ N ❍ Y	g	Stomach, gall bladder, intestinal or colon disorders?	❍ N ❍ Y
c	Asthma or other disease of lungs or respiratory organs?	❍ N ❍ Y	h	Rheumatoid arthritis or back disorders?	❍ N ❍ Y
d	Kidney stones; disease of kidney, bladder, male or female organs; or infertility?	❍ N ❍ Y	i	Paralysis, or any other physical impairment or deformity?	❍ N ❍ Y
e	Cancer, and/or cancerous tumor? (state type & part of body in details section below)	❍ N ❍ Y	j	Alcoholism or drug habit, or been a member of Alcoholics Anonymous?	❍ N ❍ Y

[3. Have you or any dependent been diagnosed or received treatment for an immune system disorder (i.e. Lupus, ITP), AIDS or an AIDS-related complex?	❍ N ❍ Y]
[4. During the past [0-5] years, have you or any dependent had hospitalization or surgery scheduled or completed, had any injury, illness, medical attention or medical advice or treatment for any reason not already mentioned?	❍ N ❍ Y]
[5. Are you or any dependent to be covered pregnant?	❍ N ❍ Y]

[If you answered "yes" to any of the questions above, please provide details below and specify the question #. Attach additional signed and dated sheets if necessary.

Question # & letter	Person treated (Last name, First name)
Condition	Treatments received
Medications prescribed	Current or future treatments or medications
Date diagnosed _ _ / _ _ / _ _ _ _	Date last seen by a doctor _ _ / _ _ / _ _ _ _

Question # & letter	Person treated (Last name, First name)
Condition	Treatments received
Medications prescribed	Current or future treatments or medications
Date diagnosed _ _ / _ _ / _ _ _ _	Date last seen by a doctor] _ _ / _ _ / _ _ _ _

Signature - please sign below if enrolling or waiving group coverage.

If you decide not to sign this authorization, Humana cannot complete your plan enrollment or determine your premium rate due to the inability to obtain the necessary information.

Employee or legal representative signature: _____ Date: _____

Name and relationship of legal representative: _____

Spouse signature: _____ Date: _____

(Only if selecting Life coverage over the guarantee issue amount.)

HumanaDental

[GENERIC]
EMPLOYER GROUP APPLICATION

Please refer to your proposal to complete this application. This document will form part of any contract issued. Print clearly in black ink, and answer all questions or indicate "not applicable."

Plan Selection

[Is this a SmartSuite selection? ❍ No ❍ Yes]

	Plan 1	Plan 2
Plan Name (as shown on your proposal)		
Coinsurance:	Participating (In) : % ____/____/____ Non-participating (Out): %____/____/____	Participating (In) : % ____/____/____ Non-participating (Out): %____/____/____
Deductible:	Participating (In): $ Non-participating (Out): $	Participating (In): $ Non-participating (Out): $
Annual Maximum:	$	$
Preventive Services Deductible Options:	❍ Apply Deductible ❍ Waive Deductible	❍ Apply Deductible ❍ Waive Deductible
Periodontic/Endodontic Options:	❍ Basic ❍ Major	❍ Basic ❍ Major
Orthodontia Options:	❍ Child Only: Lifetime Orthodontia Maximum $_____ ❍ Adult And Child: Lifetime Orthodontia Maximum $_____	
Composite Fillings for Molars:	❍ No ❍ Yes	❍ No ❍ Yes
Implant Coverage:	❍ No ❍ Yes	❍ No ❍ Yes
Out of network reimbursement options:	❍ Maximum allowable fee ❍ In-network fee schedule	❍ Maximum allowable fee ❍ In-network fee schedule
Open Enrollment [**([100+] groups only)**]:	❍ No ❍ Yes	

Underwriting Requirements

- Underwriting approval is required to offer more than one dental carrier to your employees.
- Dental coverage is available to employers with [two or more] enrolled employees.
- If the only employees of a two-life group are husband and wife, each must enroll separately as an employee and maintain eligibility. The group is only eligible if a bona fide business entity exists.
- Minimum employer contribution toward employee premium is [0-25]%. This minimum does not apply to Voluntary coverage.
- Retiree coverage is available to employers with [26 or more] enrolled employees.
- Minimum age for retiree coverage is [0-65] for employers with [26 to 50] enrolled employees and must be at least [0-50] for [51+] enrolled employees.
- Excluded class options: hourly, salary, union, non-union, management, non-management.
- If you do not maintain eligibility, underwriting, and participation requirements, we will terminate your coverage.

Participation Requirements:

Eligible Employees	Participation
[2+] (Employer Pays 100% of Premium)	[0-100]%
[2+] (Employees Contribute to Premium)	[0-75]%
[2+] Eligible Employees with Spousal Waiver	[0-50]%

Voluntary Participation Requirements:

Eligible Employees	Participation
[2+] employees	[0-Two] enrolled employees or [0-25]%, whichever is greater.

Group Information

[How much will you contribute to premium? Employee _____% Dependent _____%]

[Are you offering dental coverage to retirees? ❍ No ❍ Yes] [If yes, required age: Minimum years of service:]

[Did you have prior group dental coverage? ❍ No ❍ Yes]
[If yes, submit most recent carrier billing with effective and termination dates.]

[Did your prior dental coverage include orthodontia? ❍ No ❍ Yes]

[Will your employees have access to another carrier's dental coverage by virtue of their employment with you? ❍ No ❍ Yes]
[If yes, name of carrier:]

Thank you for choosing Humana.

[[2-99] [([TN] [2-99] & [LA] [2-99])] eligible employees]

Humana [No Worry] Program Requirements **EMPLOYER GROUP APPLICATION**

This form is for use with the Humana [[2-99] [([TN] [2-99] & [LA] [2-99])] [No Worry] program. This document will form part of any contract issued.

Humana's No Worry Commitment

[With [No Worry], you have selected a medical benefits program that provides you a [two-five] year premium rate cap on variety of medical packages.]

[Humana's [No Worry] [series 100, 200 and 300]] program guarantees that the annual medical premium rate increase will not exceed [0-15] percent for [2-5] years. You will qualify for an even lower medical premium rate cap of [0-15] percent if you meet all of the following requirements:]

- [Provide [0-100] percent your employees' email addresses and phone numbers within [0-180] days of the effective date of the [No Worry] program.]
- [[0-100] percent employee completion of the Humana Health Assessment within [0-180] days of the effective date of the [No Worry] program.]
- [Offer Humana dental coverage].]

[Humana's [No Worry] [series 400, 500 and 600]] program guarantees that the annual medical premium rate increase will not exceed [0-15] percent for [2-5] years if all of the following requirements are met:

- [Providing Humana with [0-100] percent of employees' e-mail addresses and phone numbers within [0-180] days of the effective date of the [No Worry] plan(s).]
- [Achieving at least [0-100] percent employee completion of the Humana Health Assessment within [0-180] days of the effective date of the [No Worry] plan(s).]
- [Establishing, tracking and maintaining at least [0-100] percent employee participation in a [fitness program].]
- [Establishing and maintaining at least [0-100] percent employee participation in the [Virgin HealthMiles program.]]
- [Hosting a Humana-provided seminar within [0-180] days of the effective date of the [No Worry] plan(s) outlining wellness benefits and information available to employees.]
- [If all employer requirements are not met, a standard renewal action will apply.]]

[The following is applicable to all [No Worry] programs:

- [If you offer dental coverage, Humana guarantees that the annual dental premium rate increase will not exceed [0-12] [percent] for [2-5] years (excludes DHMO).]
- [If you offer life insurance, Humana guarantees no annual premium rate increase for basic life insurance for [2-5] years.]]

[Humana will provide detailed medical benefit information for all of the plans you have selected with your [No Worry] packages. This information will be available prior to your decision to purchase [No Worry] and will not change except for legally driven reasons throughout the [2-5] year [No Worry] commitment.]

[If you purchase a [No Worry] medical plan and fail to maintain your Humana group medical insurance plan during the [No Worry] plan period and purchase group medical insurance with another carrier, you agree to pay an early termination fee according to the program parameters specified below. Your payment obligation must be satisfied no more than [0-180] days from the termination date of your group medical plan. If you discontinue offering group medical insurance, or go out of business, you do not need to pay the early termination fee.]

[Employers with [2-99] eligible employees [([TN] [2-99] & [LA] [2-99])]:

- [The early termination fee is [$0-75,000] for termination after the [0-first] year, [$0-75,000] for termination after the [second-fifth] year.]
- [The plan period is [0-5] years from the effective date of the [No Worry] plan.]]

[Thank you for choosing Humana's [No Worry] program.]

[HUMANA® *Guidance* when you need it most] [HUMANA® *Specialty Benefits*]

For insuring entities, please reference the Business Profile section of the Employer Group Application.

SERFF Tracking Number:	*HUMA-125805451*	*State:*	*Arkansas*
Filing Company:	*American Dental Providers of Arkansas, Inc.*	*State Tracking Number:*	*40183*
Company Tracking Number:			
TOI:	*H10G Group Health - Dental*	*Sub-TOI:*	*H10G.000 Health - Dental*
Product Name:	*AR APP Maint- ADPAI*		
Project Name/Number:	*/*		

Rate Information

Rate data does NOT apply to filing.

SERFF Tracking Number:	*HUMA-125805451*	*State:*	*Arkansas*
Filing Company:	*American Dental Providers of Arkansas, Inc.*	*State Tracking Number:*	*40183*
Company Tracking Number:			
TOI:	*H10G Group Health - Dental*	*Sub-TOI:*	*H10G.000 Health - Dental*
Product Name:	*AR APP Maint- ADPAI*		
Project Name/Number:	*/*		

Supporting Document Schedules

Satisfied -Name: Certification/Notice — **Review Status:** Approved-Closed — 10/06/2008

Comments:
See attached.

Attachment:
AR ADPAI Dental Certificate of Readability.pdf

Bypassed -Name: Application — **Review Status:** Approved-Closed — 10/06/2008

Bypass Reason: Refer to Form Schedule tab for application that will be used.

Comments:

Satisfied -Name: Cover Letter — **Review Status:** Approved-Closed — 10/06/2008

Comments:
See attached.

Attachment:
AR ADPAI Dental Cover Letter.pdf

Satisfied -Name: Statement of Variability — **Review Status:** Approved-Closed — 10/06/2008

Comments:
See attached.

Attachment:
Statement of Variability.Application.pdf

AMERICAN DENTAL PROVIDERS OF ARKANSAS, INC.

CERTIFICATION

I hereby certify, to the best of my knowledge and belief, that the enclosed form(s) comply(ies) with the requirements of Arkansas Insurance Code 23-80-206.

Form Number(s)	**Flesch Test Reading Ease Score**
AR-80123-BP 8/2008	40
AR-80123-SG 8/2008	40
GN-72000-HS 7/2008	40
GN-80123-HD 8/2008	40
GN-80123-NW-SB 2/2008	40

Signed by: _____

Gerald L. Ganoni
President

Date: September 4, 2008

HUMANA.
Guidance when you need it most

September 4, 2008

Arkansas Department of Insurance
1200 West Third Street
Little Rock, AR 72201-1904

RE: AMERICAN DENTAL PROVIDERS OF ARKANSAS, INC.
Group Insurance Application Filing
Form Number: AR-80123-BP 8/2008, AR-80123-SG 8/2008, GN-72000-HS 7/2008, GN-80123-HD 8/2008, GN-80123-NW-SB 2/2008
NAIC #11559
FEIN #58-2302163

Dear Sir or Madam:

We are enclosing the above-referenced forms for your review and approval. This is a new filing; the enclosed forms do not replace or supersede any like forms previously filed. These forms are for use in the group market. These forms are being filed for general use with all approved policy series and may be offered in a printed, online, or digitized audio recorded format.

This application will be used to support our currently marketed products in your state. The changes in the application reflect cosmetic changes in format, design and language. These changes are intended to create a more consumer friendly application form for our future applicants to assist them in understanding the application process.

Included with this submission are the following documents:

- Certificate of Readability; and
- Filing Fee of $100 ($20 per form).

To the best of our knowledge, we believe the attached forms satisfy the minimum requirements of applicable Arkansas statutes and regulations.

If you have any questions regarding this filing, please contact me by phone at (800) 289-0260, extension 2633, by fax at (920) 632-0479, or by e-mail at xxiong@humana.com.

Sincerely,

Xai Xiong
Contract Analyst
Humana Insurance Company

Enclosures

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Statement of Variability for Application Forms

Bracketed Sections

1. Bracketed sections will refer to an entire portion of the form such as logos, product offerings, payment information, or agreements.

2. Bracketed sections are identified by green brackets.

   NOTE: Some exceptions will apply due to state requirements or rulings regarding bracketing.

3. Non-bracketed logos, text, or numbers within the section remains constant and will not be subject to changes without being refiled.

4. Bracketed sections vary to the extent that such sections may be included, omitted or transferred to another page to suit the needs of a particular policyholder subject to any statutory or regulatory requirements.

   - For example: We have filed the Dental section of an application but the applicant did not select Dental then that section will not appear.

5. Bracketed variables such as logos, text, or numbers are subject to change as outlined within the various sections of this document.

Bracketed Numbers

1. With the exception of form numbers and matrix numbers, if allowed by the state, all bracketed numbers are variable.

   - Form numbers are located in the lower left-hand corner of the form and are not subject to change without refilling.

   - Reorder numbers (Group forms) and Revision numbers (Individual forms) are located in the lower right-hand corner of the form and are considered variable and included within this statement.

2. Bracketed numbers within a section are determined by the laws of the governing jurisdiction and will be varied only within the confines of the law.

3. Bracketed numbers will include the minimum and maximum ranges.

4. If the state determines ranges are not acceptable, only a single number will be shown on the form and that number will not be bracketed.

Bracketed Questions

1. Text within the bracketed question will not change (Refers to language only. See # 3 for formatting and placement changes).

2. Any bracketed variables within that question are subject to change.

3. Bracketed questions vary only to the extent that such questions may be included, omitted or transferred within the form subject to any statutory or regulatory requirements.

Instructions or Help Text

1. Bracketed instructional text varies to the extent that such text may be included, omitted or transferred to another page to meet the needs of applicants completing the application.

2. Humana reserves the right to make minor instructional or help text revisions, even if it is not bracketed, as needed to clarify instructions for completion of the application and amend the language to clarify the intent within the confines of the law.

Product Information

1. Product information may vary to the extent such information may be included, omitted, or transferred to another page subject to any statutory or regulatory requirements

2. Additional fields within an existing product offering section can be added to an application without refiling for the purpose of offering new insurance products or benefits subject to
    - prior approval of certificate or policy forms for the new products or benefits; and,
    - any statutory or regulatory requirements

Legal Entities

1. New product or benefit plan designs or offerings that create a new or modify an existing legal entity will require filing.

2. Legal entities will be bracketed when multiple entities are listed as insuring or administering entities. The applicable entity(s) will be shown based upon the applicant's/groups selection.

3. If there is only one legal entity listed as insuring or administering then it will not be bracketed

Demographic Information

Demographic information will not be bracketed but will fall under administrative changes which can be amended without refiling.

Administrative Changes and Clerical Errors

Humana reserves the right to amend the attached form(s) for any minor administrative changes or to fix clerical errors that may have unintentionally gone unnoticed prior to submitting for approval and to amend the language to clarify the intent within the confines of the law.

Forms are submitted in filing version format and are subject only to minor modification in paper size, stock, ink, border, and adaptation to computer printing. The application may be offered in a printed, on line, or digitized audio recorded format.